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FEDERAL PROGRAM IMPROVEMENT ACT OF 1992

AUGUST 3, 1992.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. DINGELL, from the Committee on Energy and Commerce, submitted the following

REPORT

[To accompany H.R. 3837 which on November 21, 1991, was referred jointly to the Committee on Ways and Means and the Committee on Energy and Commerce]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 3837) to make certain changes to improve the administration of the medicare program, to reform customs overtime pay practices, to prevent the payment of Federal benefits to deceased individuals, and to require reports on employers with underfunded pension plans, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Federal Program Improvement Act of 1992".

TITLE I—PROVISIONS RELATING TO THE MEDICARE PROGRAM

Subtitle A—Durable Medical Equipment

SEC. 101. RESTRICTIONS ON CERTAIN MARKETING AND SALES ACTIVITIES.

(a) PROHIBITING UNSOLICITED TELEPHONE CONTACTS FROM SUPPLIERS OF DURABLE MEDICAL EQUIPMENT TO MEDICARE BENEFICIARIES.—

57-812 O - 92 - 1

(1) IN GENERAL.—Section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)) is amended by adding at the end the following new paragraph:

"(17) PROHIBITION AGAINST UNSOLICITED TELEPHONE CONTACTS BY SUPPLIERS.—

"(A) IN GENERAL.—A supplier of a covered item under this subsection may not contact an individual enrolled under this part by telephone regarding the furnishing of a covered item to the individual (other than a covered item the supplier has already furnished to the individual) unless—

"(i) the individual gives permission to the supplier to make contact by telephone for such purpose; or

"(ii) the supplier has furnished a covered item under this subsection to the individual during the 15-month period preceding the date on which the supplier contacts the individual for such purpose.

"(B) PROHIBITING PAYMENT FOR ITEMS FURNISHED SUBSEQUENT TO UNSOLICITED CONTACTS.—If a supplier knowingly contacts an individual in violation of subparagraph (A), no payment may be made under this part for any item subsequently furnished to the individual by the supplier.

"(C) EXCLUSION FROM PROGRAM FOR SUPPLIERS ENGAGING IN PATTERN OF UNSOLICITED CONTACTS.—If a supplier knowingly contacts individuals in violation of subparagraph (A) to such an extent that the supplier's conduct establishes a pattern of contacts in violation of such subparagraph, the Secretary shall exclude the supplier from participation in the programs under this Act, in accordance with the procedures set forth in subsections (c), (f), and (g) of section 1128.".

(2) REQUIRING REFUND OF AMOUNTS COLLECTED FOR DISALLOWED ITEMS.—Section 1834(a) of such Act (42 U.S.C. 1395m(a)), as amended by paragraph (1), is amended by adding at the end the following new paragraph:

"(18) REFUND OF AMOUNTS COLLECTED FOR CERTAIN DISALLOWED ITEMS.—

"(A) IN GENERAL.—If a nonparticipating supplier furnishes to an individual enrolled under this part a covered item for which no payment may be made under this part by reason of paragraph (17)(B), the supplier shall refund on a timely basis to the patient (and shall be liable to the patient for) any amounts collected from the patient for the item, unless—

"(i) the supplier establishes that the supplier did not know and could not reasonably have been expected to know that payment may not be made for the item by reason of paragraph (17)(B), or

"(ii) before the item was furnished, the patient was informed that payment under this part may not be made for that item and the patient has agreed to pay for that item.

"(B) SANCTIONS.—If a supplier knowingly and willfully fails to make refunds in violation of subparagraph (A), the Secretary may apply sanctions against the supplier in accordance with section 1842(j)(2).

"(C) NOTICE.—Each carrier with a contract in effect under this part with respect to suppliers of covered items shall send any notice of denial of payment for covered items by reason of paragraph (17)(B) and for which payment is not requested on an assignment-related basis to the supplier and the patient involved.

"(D) TIMELY BASIS DEFINED.—A refund under subparagraph (A) is considered to be on a timely basis only if—

"(i) in the case of a supplier who does not request reconsideration or seek appeal on a timely basis, the refund is made within 30 days after the date the supplier receives a denial notice under subparagraph (C), or

"(ii) in the case in which such a reconsideration or appeal is taken, the refund is made within 15 days after the date the supplier receives notice of an adverse determination on reconsideration or appeal.".

(b) CONFORMING AMENDMENT.—Section 1834(h)(3) of such Act (42 U.S.C. 1395m(h)(3)) is amended by striking "Paragraph (12)" and inserting "Paragraphs (12) and (17)".

SEC. 102. CERTIFICATION OF PROVIDERS OF DURABLE MEDICAL EQUIPMENT.

(a) CERTIFICATION OF DURABLE MEDICAL EQUIPMENT AND OTHER SUPPLIERS; APPLICATION FOR SUPPLIER NUMBERS.—

(1) MANDATORY SUPPLIER CERTIFICATION.—

(A) IN GENERAL.—Section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)), as amended by section 101(a), is further amended by adding at the end the following new paragraph:

"(19) CERTIFICATION OF SUPPLIERS.—

"(A) IN GENERAL.—Notwithstanding any other provision of this Act (except as provided in subparagraph (D)), no payment may be made under this part for covered items furnished on or after January 1, 1994, unless the supplier furnishing the item meets the standards for certification described in subparagraph (B).

"(B) STANDARDS FOR CERTIFICATION.—A supplier meets the standards for certification described in this subparagraph if (in accordance with regulations of the Secretary) the supplier—

"(i) is in compliance with all applicable State and Federal licensure and regulatory requirements;

"(ii) maintains a physical facility and inventory on an appropriate site;

"(iii) has appropriate liability insurance;

"(iv) meets such other appropriate standards as the Secretary may establish by regulation.

"(C) PROHIBITION AGAINST DELEGATION OF CERTIFICATIONS.—The Secretary may not delegate the responsibility to certify suppliers under subparagraph (A) to any non-governmental entity.

"(D) EXCEPTION FOR SUPPLIERS WITH EXISTING PROVIDER AGREEMENTS.—Subparagraph (A) shall not apply with respect to covered items furnished by a supplier that is a provider of services that has in effect an agreement with the Secretary under section 1866(a).".

(B) REQUIRING REFUNDS OF AMOUNTS COLLECTED.—Section 1834(a)(18) of the Social Security Act (as added by section 101(a)(2)) is amended by striking "paragraph (17)(B)" each place it appears and inserting "paragraph (17)(B) or paragraph (19)(A)".

(C) PUBLICATION OF STANDARDS.—Not later than July 1, 1993, the Secretary shall publish in the Federal Register the certification standards for suppliers of covered items established under section 1834(a)(19)(B) of the Social Security Act (as added by subparagraph (A)).

(2) APPLICATIONS FOR SUPPLIER NUMBERS.—

(A) CRITERIA; INFORMATION REQUIRED.—Not later than July 1, 1993, the Secretary of Health and Human Services shall establish criteria for the application for and issuance of supplier numbers for suppliers of durable medical equipment, prosthetic devices, and urological and ostomy care supplies under part B of the medicare program, and shall include in such criteria a requirement that the supplier disclose to the Secretary the following information (to the extent that the information is not otherwise required to be disclosed under section 1124A of the Social Security Act):

(i) Information relating to the ownership of the supplier and the identity of managing employees.

(ii) The identity and billing number of other entities providing items or services for which payment may be made under the medicare program with respect to which an owner or managing employee of the supplier has or has had an ownership or control interest within the previous 3 years.

(iii) Whether any penalties (including exclusion from participation) have been assessed against any owner or managing employee of the supplier under the medicare or medicaid programs.

(iv) The identity and existence of any subcontracting or subsidiary business entities with which the provider is affiliated or doing business which are advertising or marketing firms directly or indirectly involved in sales of durable medical equipment or other supplies to medicare beneficiaries.

(v) Information on the supplier's sales and billing practices, including whether the supplier engages in telemarketing and whether items are directly purchased, warehoused, and shipped by the entity or supplied under arrangements with other suppliers.

(vi) Documentation regarding whether the supplier is certified as a durable medical equipment supplier by the Secretary.

(vii) Any other information the Secretary considers appropriate.

(B) PROHIBITION AGAINST MULTIPLE BILLING NUMBERS.—The Secretary may not issue more than one billing number to any supplier described in subparagraph (A), unless the issuance of more than one number is appropriate to identify subsidiary or regional entities under the supplier's ownership or control.

(C) EXCEPTION FOR PROVIDERS OF SERVICES.—The standards established pursuant to subparagraph (A) and the prohibition described in subparagraph (B) shall not apply with respect to any supplier described in subparagraph (A) that is a provider of services that has in effect an agreement with the Secretary under section 1866(a) of the Social Security Act.

(b) STUDY OF CERTIFICATION AND QUALITY CRITERIA.—

(1) STUDY.—The Secretary of Health and Human Services (in consultation with representatives of suppliers of durable medical equipment under the medicare program and such other individuals or organizations as the Secretary considers appropriate) shall conduct a study of the feasibility and desirability of establishing and implementing additional certification and quality assurance criteria for suppliers of durable medical equipment, prosthetic devices, and urological and ostomy care supplies under part B of the medicare program, and shall include in the study an analysis of standards relating to safety, patient records and rights, equipment management and maintenance, qualifications of employees (including the appropriate use of certified respiratory therapists in providing home oxygen therapy services), and internal quality assurance programs.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit a report on the study conducted under paragraph (1) to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

SEC. 103. REFORM OF PROCEDURES FOR FILING, PROCESSING, AND REVIEWING CLAIMS.

(a) PROHIBITION AGAINST CARRIER SHOPPING.—

(1) IN GENERAL.—Section 1834(a)(12) of the Social Security Act (42 U.S.C. 1395m(a)(12)) is amended to read as follows:

"(12) USE OF CARRIERS TO PROCESS CLAIMS.—

"(A) DESIGNATION OF REGIONAL CARRIERS.—The Secretary may designate, by regulation under section 1842, one carrier for one or more entire regions to process all claims within the region for covered items under this section.

"(B) PROHIBITION AGAINST CARRIER SHOPPING.—(i) No supplier of a covered item may present or cause to be presented a claim for payment under this part unless such claim is presented to the appropriate carrier.

"(ii) For purposes of clause (i), the term 'appropriate carrier' means the carrier having jurisdiction over the geographic area that includes the location where the item was directly furnished to the patient.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items furnished on or after July 1, 1993.

(3) CLARIFICATION OF AUTHORITY TO DESIGNATE CARRIERS FOR OTHER ITEMS AND SERVICES.—Nothing in this subsection or the amendment made by this subsection may be construed to restrict the authority of the Secretary of Health and Human Services to designate regional carriers or modify claims jurisdiction rules with respect to items or services under part B of the medicare program that are not covered items under section 1834(a) of the Social Security Act or prosthetic devices or orthotics and prosthetics under section 1834(h) of such Act.

(b) CERTIFICATES OF MEDICAL NECESSITY FOR ITEMS OF DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, AND ORTHOTICS AND PROSTHETICS.—Not later than July 1, 1993, the Secretary of Health and Human Services shall, in consultation with carriers under part B of the medicare program, develop one or more standardized certificates of medical necessity for durable medicare equipment, prosthetic devices, and orthotics and prosthetics to be completed by each physician who prescribes such an item for any medicare beneficiary and transmitted to the carrier processing the claim for payment for the item under the program and to the beneficiary receiving the item.

(c) COVERAGE AND REVIEW CRITERIA.—

(1) DEVELOPMENT AND ESTABLISHMENT.—Not later than July 1, 1993, the Secretary of Health and Human Services, in consultation with representatives of suppliers of durable medical equipment, individuals enrolled under part B of the medicare program, and appropriate medical specialty societies, shall develop and establish uniform national coverage and utilization review criteria for 200 items of durable medical equipment, prosthetic devices, orthotics and prosthetics, and surgical dressings selected in accordance with the standards described in paragraph (2). The Secretary shall publish the criteria as part of the instructions provided to fiscal intermediaries and carriers under the medicare program.

(2) STANDARDS FOR SELECTING ITEMS SUBJECT TO CRITERIA.—The Secretary may select an item for coverage under the criteria developed and established under paragraph (1) if the Secretary finds that—

(A) the item is frequently purchased or rented by beneficiaries;

(B) the item is frequently subject to a determination that it is not medically necessary; or

(C) the coverage or utilization criteria applied to the item (as of the date of the enactment of this Act) is not consistent among carriers.

(3) ANNUAL REVIEW AND EXPANSION OF ITEMS SUBJECT TO CRITERIA.—The Secretary shall annually review the coverage and utilization of items of durable medical equipment, prosthetic devices, orthotics and prosthetics, and surgical dressings to determine whether items not included among the items initially selected under paragraph (1) should be made subject to uniform national coverage and utilization review criteria, and, if appropriate, shall apply such criteria to such additional items.

(4) REPORT ON EFFECT OF UNIFORM CRITERIA ON UTILIZATION OF ITEMS.—Not later than January 1, 1994, the Secretary shall submit a report to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate analyzing the impact of the uniform criteria established under paragraph (1) on the utilization of items of durable medical equipment, prosthetic devices, orthotics and prosthetics, and surgical dressings by individuals enrolled under part B of the medicare program, and shall include in the report recommendations regarding the development and establishment of uniform coverage and utilization criteria for additional items under the program.

SEC. 104. ADJUSTMENTS FOR INHERENT REASONABLENESS.

(a) ADJUSTMENTS MADE TO FINAL PAYMENT AMOUNTS.—Section 1834(a)(10)(B) of the Social Security Act (42 U.S.C. 1395m(a)(10)(B)) is amended by adding at the end the following: "In applying such provisions to payments for an item under this subsection, the Secretary shall make adjustments to the payment basis for the item described in paragraph (1)(B) if the Secretary determines (in accordance with such provisions and on the basis of prices and costs applicable at the time the item is furnished) that such payment basis is not inherently reasonable.".

(b) ADJUSTMENT REQUIRED FOR CERTAIN ITEMS.—

(1) IN GENERAL.—In accordance with section 1834(a)(10)(B) of the Social Security Act (as amended by subsection (a)), the Secretary of Health and Human Services shall determine whether the payment amounts for the items described in paragraph (2) are not inherently reasonable, and shall adjust such amounts in accordance with such section if the amounts are not inherently reasonable.

(2) ITEMS DESCRIBED.—The items referred to in paragraph (1) are decubitus care equipment, transcutaneous electrical nerve stimulators, and any other items considered appropriate by the Secretary.

SEC. 105. ADVANCED DETERMINATION REQUIREMENTS FOR POTENTIALLY OVERUSED ITEMS.

(a) TREATMENT OF POTENTIALLY OVERUSED ITEMS AND ADVANCED DETERMINATIONS OF COVERAGE.—

(1) IN GENERAL.—Section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)), as amended by sections 101 and 102, is further amended by adding at the end the following new paragraph:

"(20) SPECIAL TREATMENT FOR POTENTIALLY OVERUSED ITEMS.—

"(A) DEVELOPMENT OF LIST OF ITEMS BY SECRETARY.—The Secretary shall develop and periodically update a list of items for which payment may be made under this subsection that are potentially overused, and shall include in such list seat-lift mechanisms, transcutaneous electrical nerve stimulators, motorized scooters, decubitus care mattresses, and any such other item determined by the Secretary to be potentially overused on the basis of any of the following criteria—

"(i) the item is marketed directly to potential patients;

"(ii) the item is marketed with an offer to potential patients to waive the costs of coinsurance associated with the item or is marketed as being available at no cost to policyholders of a medicare supplemental policy (as defined in section 1882(g)(1));

"(iii) the item has been subject to a consistent pattern of overutilization; or

"(iv) a high proportion of claims for payment for such item under this part may not be made because of the application of section 1862(a)(1).

"(B) ITEMS SUBJECT TO SPECIAL CARRIER SCRUTINY.—Payment may not be made under this part for any item contained in the list developed by the Secretary under subparagraph (A) unless the carrier has subjected the claim for payment for the item to special scrutiny or has followed the procedures described in paragraph (11)(C) with respect to the item.".

(2) ADVANCE CARRIER DETERMINATIONS FOR CUSTOMIZED ITEMS.—Section 1834(a)(11) of such Act (42 U.S.C. 1395m(a)(11)) is amended by adding at the end the following new subparagraph:

"(C) CARRIER DETERMINATIONS FOR CERTAIN ITEMS IN ADVANCE.—Upon the request of a supplier, a carrier shall determine in advance whether payment for an item may not be made under this subsection because of the application of section 1862(a)(1) if—

"(i) the item is a customized item (other than inexpensive items specified by the Secretary); or

"(ii) the item is subject to special carrier scrutiny under paragraph (20)(B).".

(3) REQUIRING CARRIERS TO MEET CRITERIA RELATING TO TIMELY RESPONSE TO REQUESTS.—Section 1842(c) of such Act (42 U.S.C. 1395u(c)) is amended by adding at the end the following new paragraph:

"(4) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall require the carrier to meet criteria developed by the Secretary to measure the timeliness of carrier responses to requests for payment of items described in section 1834(a)(11)(C).".

(4) TECHNICAL AMENDMENT.—Section 1834(h)(3) of such Act is amended by striking "paragraph (10) and paragraph (11)" and inserting "paragraphs (10) and (11)".

(5) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items furnished on or after July 1, 1993.

(b) REPORT ON IMPLEMENTATION AND REVIEW OF POTENTIALLY OVERUSED ITEMS.—Not later than July 1, 1993, the Secretary of Health and Human Services shall submit a report to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate describing the steps the Secretary has taken to carry out the provisions of section 1834(a) of the Social Security Act requiring advance coverage determinations or special carrier scrutiny for certain items, together with an analysis of the effectiveness of such requirements in reducing unnecessary utilization of items of durable medical equipment under part B of the medicare program.

SEC. 106. PROHIBITION AGAINST CERTAIN FINANCIAL ARRANGEMENTS BETWEEN REFERRING PHYSICIANS AND SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.

(a) IN GENERAL.—Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended by inserting "or durable medical equipment" after "clinical laboratory services" each place it appears in subsections (a)(1), (b)(2)(A)(ii)(I), (d)(1), (d)(2), and (d)(3).

(b) OTHER CONFORMING AMENDMENTS.—Section 1877 of such Act (42 U.S.C. 1395nn) is further amended—

(1) in subsection (b)(2)(A)(ii)(II), by striking "laboratory services," and inserting "laboratory services of furnishing of the groups' durable medical equipment,";

(2) in subsection (d)(2), by inserting "or the supplier furnishing the equipment" after "furnishing the services";

(3) in subsection (d)(3)—

(A) by inserting "or furnished" after "provided", and

(B) in subparagraph (A), by inserting "or furnish equipment" after "perform services";

(4) in subsection (g)(1), by inserting "or an item of durable medical equipment" after "laboratory service";

(5) in subsection (g)(3), by inserting "or item" after "service" each place it appears; and

(6) in subsection (h)(7)(B) by inserting "or the furnishing of the item of durable medical equipment" after "laboratory service".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply with respect to covered items of durable medical equipment furnished on or after January 1, 1994.

SEC. 107. REPORTS AND STUDIES.

(a) ITEMS REQUIRING IMPROVED DEFINITIONS.—The Secretary of Health and Human Services (in consultation with the Inspector General of the Department of

Health and Human Services, manufacturers of durable medical equipment, and entities that establish quality standards for items of durable medical equipment) shall prepare a list of items of durable medical equipment that require improved definitions, including improvements relating to the incorporation of updated quality considerations for the items, for purposes of part B of the medicare program, and shall submit a report on changes made to improve the definitions of items on such list to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate not later than January 1, 1993.

(b) GEOGRAPHIC VARIATION AMONG SUPPLIER COSTS COMPARED TO PAYMENT AMOUNTS.—

(1) COLLECTION AND ANALYSIS OF SUPPLIER COST DATA.—The Administrator of the Health Care Financing Administration shall, in consultation with appropriate organizations, collect data on supplier costs of durable medical equipment for which payment may be made under part B of the medicare program, and shall analyze such data to determine the proportions of such costs attributable to the service and product components of furnishing such equipment and the extent to which such proportions vary by type of equipment and by the geographic region in which the supplier is located.

(2) DEVELOPMENT OF GEOGRAPHIC ADJUSTMENT INDEX; REPORTS.—Not later than July 1, 1993, the Administrator shall submit a report to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate on the data collected and the analysis conducted under subparagraph (A), and shall include in such report—

(A) an analysis on a geographic basis of the supplier costs of durable medical equipment under the medicare program;

(B) the Administrator's recommendations for a geographic cost adjustment index for suppliers of durable medical equipment under the medicare program and an analysis of the impact of such proposed index on payments under the medicare program; and

(C) an analysis of the feasibility and desirability of establishing a national fee schedule for determining the amount of payment for items of durable medical equipment under the medicare program, together with recommendations regarding the design of such a fee schedule (including whether fees should be based on the average or median of current payment amounts or on another basis).

(3) DURABLE MEDICAL EQUIPMENT DEFINED.—In this subsection, the term "durable medical equipment" means covered items under section 1834(a) of the Social Security Act, prosthetic devices, orthotics and prosthetics, ostomy bags and supplies, and surgical dressings.

(c) CRITERIA FOR TREATMENT OF ITEMS AS PROSTHETICS DEVICES OR ORTHOTICS AND PROSTHETICS.—Not later than July 1, 1993, the Secretary of Health and Human Services shall submit a report to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate describing items of durable medical equipment treated as prosthetic devices or orthotics and prosthetics for purposes of determining the amount of payment for such items under part B of the medicare program that do not require individualized or custom fitting and adjustment to be used by a patient, and shall include in such report recommendations for an appropriate methodology for determining the amount of payment for such items under such program.

Subtitle B—Secondary Payer Identification and Enforcement

SEC. 111. IMPROVING IDENTIFICATION OF MEDICARE SECONDARY PAYER SITUATIONS.

(a) SURVEY OF BENEFICIARIES.—

(1) IN GENERAL.—Section 1862(b)(5) of the Social Security Act (42 U.S.C. 1395y(b)(5)) is amended by adding at the end the following new subparagraph:

"(D) OBTAINING INFORMATION FROM BENEFICIARIES.—Before an individual applies for benefits under part A or enrolls under part B, the Administrator shall mail the individual a questionnaire to obtain information on whether the individual is covered under a primary plan and the nature of the coverage provided under the plan, including the name, address, and identifying number of the plan.".

(2) DISTRIBUTION OF QUESTIONNAIRE BY CONTRACTOR.—The Secretary of Health and Human Services shall enter into an agreement with an entity to distribute the questionnaire described in section 1862(b)(5)(D) of the Social Security Act (as added by paragraph (1)) not later than January 1, 1993.

(b) MANDATORY SCREENING BY PROVIDERS AND SUPPLIERS UNDER PART B.—

(1) IN GENERAL.—Section 1862(b) of such Act (42 U.S.C. 1395y(b)) is amended by adding at the end the following new paragraph:

"(6) SCREENING REQUIREMENTS FOR PROVIDERS AND SUPPLIERS.—

"(A) IN GENERAL.—Notwithstanding any other provision of this title, no payment may be made for any item or service furnished under part B unless the entity furnishing such item or service completes (to the best of its knowledge and on the basis of information obtained from the individual to whom the item or service is furnished) the portion of the claim form relating to the availability of other health benefit plans.

"(B) PENALTIES.—An entity that knowingly, willfully, and repeatedly fails to complete a claim form in accordance with subparagraph (A) or provides inaccurate information relating to the availability of other health benefit plans on a claim form under such subparagraph shall be subject to a civil money penalty of not to exceed $2,000 for each such incident. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to items and services furnished on or after January 1, 1993.

SEC. 112. IMPROVEMENTS IN RECOVERY OF PAYMENTS FROM PRIMARY PAYERS.

(a) SUBMISSION OF REPORTS ON EFFORTS TO RECOVER ERRONEOUS PAYMENTS.—

(1) FISCAL INTERMEDIARIES UNDER PART A.—Section 1816 of the Social Security Act (42 U.S.C. 1396h) is amended by adding at the end the following new subsection:

"(k) An agreement with an agency or organization under this section shall require that such agency or organization submit an annual report to the Secretary describing the steps taken to recover payments made for items or services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)).".

(2) CARRIERS UNDER PART B.—Section 1842(b)(3) of such Act (42 U.S.C. 1395u(b)(3)) is amended—

(A) by striking "and" at the end of subparagraphs (G) and (H); and

(B) by inserting after subparagraph (H) the following new subparagraph:

"(I) will submit annual reports to the Secretary describing the steps taken to recover payments made under this part for items or services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)).".

(b) REQUIREMENTS UNDER CARRIER PERFORMANCE EVALUATION PROGRAM.—

(1) FISCAL INTERMEDIARIES UNDER PART A.—Section 1816(f)(1)(A) of such Act (42 U.S.C. 1396h(f)(1)(A)) is amended by striking "processing" and inserting "processing (including the agency's or organization's success in recovering payments made under this title for services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)))".

(2) CARRIERS UNDER PART B.—Section 1842(b)(2) of such Act (42 U.S.C. 1395u(b)(2)) is amended by adding at the end the following new subparagraph:

"(D) In addition to any other standards and criteria established by the Secretary for evaluating carrier performance under this paragraph relating to avoiding erroneous payments, the Secretary shall establish standards and criteria relating to the carrier's success in recovering payments made under this part for items or services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)).".

(c) DEADLINE FOR REIMBURSEMENT BY PRIMARY PLANS.—

(1) IN GENERAL.—Section 1862(b)(2)(B)(i) of such Act (42 U.S.C. 1395y(b)(2)(B)(i)) is amended by adding at the end the following sentence: "If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date such notice or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).".

(2) CONFORMING AMENDMENT.—The heading of clause (i) of section 1862(b)(2)(B) of such Act is amended to read as follows: "REPAYMENT REQUIRED.—".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to payments for items and services furnished on or after January 1, 1993.

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to contracts with fiscal intermediaries and carriers under title XVIII of the Social Security Act for years beginning with 1993.

SEC. 113. STUDY OF EFFECTIVENESS OF SECONDARY PAYER REFORMS.

(a) IN GENERAL.—The Comptroller General shall conduct a study of the effectiveness of the amendments made by this subtitle in improving collections from primary plans for expenditures under the medicare program for which medicare is a secondary payer, and shall include in the study—

(1) an evaluation of the feasibility and desirability of providing incentives to entities serving as carriers and fiscal intermediaries under the medicare program to recover amounts paid under the program for items and services for which payment should not have been made under the program because of the medicare secondary payer requirements; and

(2) an analysis of the feasibility and desirability of permitting entities that are not engaged in providing, paying for, or reimbursing the cost of medical or other health services under group insurance policies or contracts or similar agreements or arrangements to serve as fiscal intermediaries and carriers under the medicare program.

(b) REPORTS.—Not later than July 1, 1993, the Comptroller General shall submit interim findings on the study conducted under subsection (a) to the Committee on Ways and Means of the House of Representatives. Not later than March 1, 1994, the Comptroller General shall submit a final report on the study to the Committee, and shall include in the report any recommendations the Comptroller General considers appropriate for actions to improve collections from primary plans for expenditures for which medicare is a secondary payer.

Subtitle C—Payment for Interpretation of Electrocardiograms

SEC. 121. PERMITTING SEPARATE PAYMENT FOR INTERPRETATION OF ELECTROCARDIOGRAMS.

(a) DEVELOPMENT OF SEPARATE FEE SCHEDULE AMOUNTS FOR ELECTROCARDIOGRAM INTERPRETATIONS.—Effective for services furnished on or after January 1, 1993—

(1) IN GENERAL.—The Secretary of Health and Human Services—

(A) shall make separate payment, under the fee schedule established under section 1848 of the Social Security Act, for the interpretation of electrocardiograms performed or ordered to be performed as part of or in conjunction with a visit to or a consultation with a physician, and

(B) shall adjust the relative values established for medical visits and consultations under subsection (c) of such section so as not to include relative value units for electrocardiogram interpretation in the relative value for medical visits and consultations.

(2) CONFORMING AMENDMENT.—Section 1848(b) of the Social Security Act (42 U.S.C. 1395w-4(b)) is amended by striking paragraph (3).

(b) BUDGET NEUTRALITY.—Effective for services furnished on or after January 1, 1993—

(1) the Secretary shall reduce the relative values for all services established under section 1848(c)(2) of the Social Security Act by such percentage as the Secretary determines to be necessary so that, beginning in 1996, the provisions of this section would not result in expenditures under section 1848 of such Act that exceed the amount of such expenditures under such section that would have been made if this section had not been enacted, and

(2) the Secretary shall reduce the amount determined under section 1848(a)(2)(B)(i)(I) of such Act by such percentage as the Secretary determines to be required to assure that, taking into account the reduction in relative values made under paragraph (1), the provisions of this section do not result in expenditures under section 1848 of such Act in 1993 that exceed the amount of such expenditures under such section that would have been made if this section had not been enacted.

TITLE II—CUSTOMS OFFICER PAY REFORM

SEC. 201. OVERTIME AND PREMIUM PAY FOR CUSTOMS OFFICERS.

(a) IN GENERAL.—Section 5 of the Act of February 13, 1911 (19 U.S.C. 261 and 267) is amended to read as follows:

"SEC. 5. OVERTIME AND PREMIUM PAY FOR CUSTOMS OFFICERS.

"(a) OVERTIME PAY.—

"(1) IN GENERAL.—Subject to paragraph (2) and subsection (c), a customs officer who is officially assigned to perform work in excess of 40 hours in the administrative workweek of the officer or in excess of 8 hours in a day shall be compensated for that work at an hourly rate of pay that is equal to 2 times the hourly rate of the basic pay of the officer. For purposes of this paragraph, the hourly rate of basic pay for a customs officer does not include any premium pay provided for under subsection (b).

"(2) SPECIAL PROVISIONS RELATING TO OVERTIME WORK ON CALLBACK BASIS.—

"(A) MINIMUM DURATION.—Any work for which compensation is authorized under paragraph (1) and for which the customs officer is required to return to the officer's place of work shall be treated as being not less than 2 hours in duration; but only if such work begins at least 1 hour after the end of any previous regularly scheduled work assignment.

"(B) COMPENSATION FOR COMMUTING TIME.—

"(i) IN GENERAL.—Except as provided in clause (ii), in addition to the compensation authorized under paragraph (1) for work to which subparagraph (A) applies, the customs officer is entitled to be paid, as compensation for commuting time, an amount equal to 3 times the hourly rate of basic pay of the officer.

"(ii) EXCEPTION.—Compensation for commuting time is not payable under clause (i) if the work for which compensation is authorized under paragraph (1) commences within 2 hours of the next regularly scheduled work assignment of the customs officer.

"(b) PREMIUM PAY FOR CUSTOMS OFFICERS.—

"(1) NIGHT WORK DIFFERENTIAL.—

"(A) 3 P.M. TO MIDNIGHT SHIFTWORK.—If the majority of the hours of regularly scheduled work of a customs officer occur during the period beginning at 3 p.m. and ending at 12 a.m., the officer is entitled to pay for work during such period (except for work to which paragraph (2) or (3) applies) at the officer's hourly rate of basic pay plus premium pay amounting to 15 percent of that basic rate.

"(B) 11 P.M. TO 8 A.M. SHIFTWORK.—If the majority of the hours of regularly scheduled work of a customs officer occur during the period beginning at 11 p.m. and ending at 8 a.m., the officer is entitled to pay for work during such period (except for work to which paragraph (2) or (3) applies) at the officer's hourly rate of basic pay plus premium pay amounting to 20 percent of that basic rate.

"(2) SUNDAY DIFFERENTIAL.—A customs officer who performs any regularly scheduled work on a Sunday that is not a holiday is entitled to pay for that work at the officer's hourly rate of basic pay plus premium pay amounting to 50 percent of that basic rate.

"(3) HOLIDAY DIFFERENTIAL.—A customs officer who performs any regularly scheduled work on a holiday is entitled to pay for that work at the officer's hourly rate of basic pay plus premium pay amounting to 100 percent of that basic rate.

"(4) TREATMENT OF PREMIUM PAY.—Premium pay provided for under this subsection may not be treated as being overtime pay or compensation for any purpose.

"(c) LIMITATIONS.—

"(1) FISCAL YEAR CAP.—The aggregate of overtime pay under subsection (a) (including commuting compensation under subsection (a)(2)(B)) and premium pay under subsection (b) that a customs officer may be paid in any fiscal year may not exceed $25,000; except that the Commissioner of Customs or his designee may waive this limitation in individual cases in order to prevent excessive costs or to meet emergency requirements of the Customs Service.

"(2) EXCLUSIVITY OF PAY UNDER THIS SECTION.—A customs officer who receives overtime pay under subsection (a) or premium pay under subsection (b) for time

worked may not receive pay or other compensation for that work under any other provision of law.

"(d) REGULATIONS.—The Secretary of the Treasury shall prescribe such regulations as are necessary or appropriate to carry out this section, including regulations—

"(1) to ensure that callback work assignments are commensurate with the overtime pay authorized for such work; and

"(2) to prevent the disproportionate assignment of overtime work to customs officers who are near to retirement.

"(e) DEFINITIONS.—As used in this section:

"(1) The term 'customs officer' means an individual performing those functions specified by regulation by the Secretary of the Treasury for a customs inspector or canine enforcement officer. Such functions shall be consistent with such applicable standards as may be promulgated by the Office of Personnel Management.

"(2) The term 'holiday' means any day designated as a holiday under a Federal statute or Executive order.".

(b) CONFORMING AMENDMENTS.—

(1) Section 2 of the Act of June 3, 1944 (19 U.S.C. 1451a), is repealed.

(2) Section 450 of the Tariff Act of 1930 (19 U.S.C. 1450) is amended—

(A) by striking out "**AT NIGHT**" in the section heading and inserting "**DURING OVERTIME HOURS**";

(B) by striking out "at night" and inserting "during overtime hours"; and

(C) by inserting "aircraft," immediately before "vessel".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) apply to customs inspectional services provided on or after October 1, 1992.

SEC. 202. FOREIGN LANGUAGE PROFICIENCY AWARDS FOR CUSTOMS OFFICERS.

Cash awards for foreign language proficiency may, under regulations prescribed by the Secretary of the Treasury, be paid to customs officers (as referred to in section 5(e)(1) of the Act of February 13, 1911) to the same extent and in the same manner as would be allowable under subchapter III of chapter 45 of title 5, United States Code, with respect to law enforcement officers (as defined by section 4521 of such title).

SEC. 203. APPROPRIATIONS REIMBURSEMENTS FROM THE CUSTOMS USER FEE ACCOUNT.

Section 13031(f)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(f)(3)) is amended—

(1) by amending clause (i) of subparagraph (A) to read as follows:

"(i) in—

"(I) paying overtime compensation and premium pay under section 5(a) and (b) of the Act of February 13, 1911,

"(II) paying agency contributions to the Civil Service Retirement and Disability Fund to match deductions from the overtime compensation paid under subclause (I), and

"(III) providing all preclearance services for which the recipients of such services are not required to reimburse the Secretary of the Treasury, and"; and

(2) by striking out "except for costs described in subparagraph (A)(i) (I) and (II)," in subparagraph (B)(i).

SEC. 204. TREATMENT OF CERTAIN PAY OF CUSTOMS OFFICERS FOR RETIREMENT PURPOSES.

(a) IN GENERAL.—Section 8331(3) of title 5, United States Code, is amended—

(1) by striking out "and" at the end of subparagraph (C);

(2) by striking out the semicolon at the end of subparagraph (D) and inserting "; and";

(3) by adding after subparagraph (D) the following:

"(E) with respect to a customs officer (referred to in subsection (e)(1) of section 5 of the Act of February 13, 1911), compensation for overtime inspectional services provided for under subsection (a) of such section 5, but not to exceed 50 percent of any statutory maximum in overtime pay for customs officers which is in effect for the year involved;"; and

(4) by striking out "subparagraphs (B), (C), and (D) of this paragraph," and inserting "subparagraphs (B), (C), (D), and (E) of this paragraph".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on the date of the enactment of this Act and apply only with respect to service performed on or after such date.

SEC. 205. REPORTS.

(a) CUSTOMS USER FEE ACCOUNT REPORTS.—Subparagraph (D) of section 13031(f)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(f)(3)(D)) is amended to read as follows:

"(D) At the close of each fiscal year, the Secretary of the Treasury shall submit a report to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives—

"(i) containing a detailed accounting of all expenditures from the Customs User Fee Account during such year, including a summary of the expenditures, on a port-by-port basis, for which reimbursement has been provided under subparagraph (A)(ii); and

"(ii) containing a listing of all callback assignments of customs officers for which overtime compensation was paid under section 5(a) of the Act of February 13, 1911, and that were less than 1 hour in duration.".

(b) OTHER REPORTS.—

(1) GAO REPORT.—The Comptroller General of the United States shall undertake—

(A) an evaluation of the appropriateness and efficiency of the customs user fee laws for financing the provision of customs inspectional services; and

(B) a study to determine whether cost savings in the provision of overtime inspectional services could be realized by the United States Customs Service through the use of additional inspectors as opposed to continuing the current practice of relying on overtime pay.

The Comptroller General shall submit a report on the evaluation and study required under this subsection to the Committees by no later than the 1st anniversary of the date of the enactment of this Act.

(2) TREASURY RECOMMENDATION.—On the day that the President submits the budget for the United States Government for fiscal year 1994 to the Congress under section 1105(a) of title 31, United States Code, the Secretary of the Treasury shall submit to the Committees recommended legislative proposals for improving the operation of customs user fee laws in financing the provision of customs inspectional services.

(3) DEFINITION OF COMMITTEES.—For purposes of this subsection, the term "Committees" means the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate.

TITLE III—AVAILABILITY AND USE OF DEATH INFORMATION UNDER THE OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM

SEC. 301. IMPROVEMENTS IN PROGRAM FOR USE OF DEATH CERTIFICATES TO CORRECT PROGRAM INFORMATION.

(a) ELIMINATION OF STATE RESTRICTIONS ON USE OF INFORMATION.—Section 205(r)(1) of the Social Security Act (42 U.S.C. 405(r)(1)) is amended by adding at the end, after and below subparagraph (B), the following new sentence:

"Any contract entered into pursuant to subparagraph (A) shall not include any restriction on the use of information obtained by the Secretary pursuant to such contract, except to the extent that such use may be restricted under paragraph (6).".

(b) INFORMATION PROVIDED TO STATE AGENCIES FREE OF CHARGE.—

(1) IN GENERAL.—Section 205(r)(4) of such Act (42 U.S.C. 405(r)(4)) is amended to read as follows:

"(4)(A) In the case of individuals with respect to whom federally funded benefits are provided by (or through) a State agency other than under this Act, the Secretary shall to the extent feasible provide such information free of charge through a cooperative arrangement with such agency, for ensuring proper payment of those benefits with respect to such individuals, if such arrangement does not conflict with the duties of the Secretary under paragraph (1).

"(B) The Secretary may enter into similar agreements with States to provide information free of charge for their use in programs wholly funded by the States if such arrangement does not conflict with the duties of the Secretary under paragraph (1).".

(2) CONFORMING AMENDMENT.—Section 205(r)(3) of such Act (42 U.S.C. 405(r)(3)) is amended by striking "or State".

(c) USE BY STATES OF SOCIAL SECURITY ACCOUNT NUMBERS CONTINGENT UPON PARTICIPATION IN PROGRAM.—Section 205(r)(2) of such Act (42 U.S.C. 405(r)(2)) is amended—

(1) by inserting "(A)" after "(2)"; and

(2) by adding at the end the following new subparagraph:

"(B) Notwithstanding section 7(a)(2)(B) of the Privacy Act of 1974 and clauses (i) and (v) of subsection (c)(2)(C) of this section, any State which is not a party to a contract with the Secretary meeting the requirements of paragraph (1) (and any political subdivision thereof) may not utilize an individual's social security account number in the administration of any driver's license or motor vehicle registration law.".

SEC. 302. STUDY REGARDING IMPROVEMENTS IN GATHERING AND REPORTING OF DEATH INFORMATION.

(a) IN GENERAL.—As soon as practicable after the date of the enactment of this Act, the Secretary of Health and Human Services shall conduct a study of possible improvements in the current methods of gathering and reporting death information by the Federal, State, and local governments which would result in more efficient and expeditious handling of such information.

(b) SPECIFIC MATTERS TO BE STUDIED.—In carrying out the study required under this section, the Secretary shall—

(1) ascertain the delays in the receipt of death information which are currently encountered by the Social Security Administration and other agencies in need of such information on a regular basis,

(2) analyze the causes of such delays,

(3) develop alternative options for improving Federal, State, and local agency cooperation in reducing such delays, and

(4) evaluate the costs and benefits associated with the options referred to in paragraph (3).

(c) REPORT.—Not later than December 31, 1992, the Secretary shall submit a written report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate setting forth the results of the study conducted pursuant to this section, together with such administrative and legislative recommendations as the Secretary may consider appropriate.

SEC. 303. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by section 301 shall take effect 1 year after the date of the enactment of this Act.

(b) PROMOTION OF ENTRY INTO NEW CONTRACTS.—As soon as practicable after the date of the enactment of this Act, the Secretary of Health and Human Services shall take such actions as are necessary and appropriate to promote entry into contracts under section 205(r) of the Social Security Act which are in compliance with the requirements of the amendments made by section 301.

TITLE IV—PBGC REPORT ON EMPLOYERS WITH UNDERFUNDED PLANS

SEC. 401. REPORT ON EMPLOYERS WITH UNDERFUNDED PLANS.

(a) GENERAL RULE.—The Pension Benefit Guaranty Corporation shall, on January 31 of each calendar year after 1991, submit a report to the Congress setting forth—

(1) the name of each contributing sponsor of 1 or more applicable plans having unfunded liabilities aggregating $25,000,000 or more, and

(2) the name of each contributing sponsor with an applicable plan which has an unfunded liability in excess of $5,000,000 and with respect to which a minimum funding waiver in excess of $1,000,000 has been granted.

Information may be included in such report only if such information may be publicly disclosed by the Pension Benefit Guaranty Corporation.

(b) DETERMINATIONS OF UNFUNDED LIABILITY.—For purposes of subsection (a), determinations of the unfunded liability of any plan shall be made by the Pension Benefit Guaranty Corporation on the basis of the most recent information available to it.

(c) APPLICABLE PLAN.—For purposes of subsection (a), the term "applicable plan" means any employee pension benefit plan (as defined in paragraph (2) of section 3 of the Employee Retirement Income Security Act of 1974) covered under subtitle B of title IV of such Act; except that such term shall not include a multiemployer plan (as defined in section 4001(a)(3) of such Act).

57-812 O - 92 - 2

(d) CONTRIBUTING SPONSOR.—For purposes of this section, the term "contributing sponsor" has the meaning given to such term by section 4001(a)(13) of such Act.

PURPOSE AND SUMMARY

The purpose of the bill is to make a number of changes in the administration of the Medicare program, as well as other changes to matters not within the jurisdiction of this Committee. Title I of the bill, which includes material related to the Medicare program, would revise current policies affecting the administration and payment of claims for covered items of durable medical equipment (DME) to reduce fraud, waste, and abuse. The reported bill also includes provisions that would strengthen enforcement of the Medicare secondary payer policy, and reduce the level of erroneous payments. Finally, Title I of the bill includes a provision to restore separate Medicare payments to physicians for interpretation of electrocardiograms.

BACKGROUND AND NEED FOR THE LEGISLATION

The Medicare portions of this legislation are the result of the oversight and investigative activities of the Committee on Ways and Means. Based on a series of hearings and investigations conducted by the Subcommittee on Oversight of the Committee on Ways and Means, considerable evidence was accumulated concerning the practices of certain durable medical equipment (DME) suppliers and the manner in which the Medicare program administers claims for covered DME items. These investigations and hearings also identified problems in the enforcement of Medicare requirements concerning the primary liability of certain other health plans.

The Committee is also aware of a number of recommendations from the Department of Health and Human Services (DHHS) and from organizations representing physicians and DME suppliers that support the provisions included in its reported bill. The Committee is also aware that the Inspector General of DHHS has reported on a number of problems and abuses in the marketing of DME items to Medicare beneficiaries and significant variations in the application of Medicare coverage and payment policies by carriers. These matters are well documented in reports and hearings considered by the Committee.

At a time of rising health care costs and limited public resources to support the Medicare program, the Committee believes strongly that every effort must be made to assure the effective and economical administration of the program. Program waste, fraud or abuse must be eliminated. The provisions related to the administration of the Medicare DME benefit are intended to improve program integrity and management.

The Committee reported bill would also address a problem arising from implementation of certain provisions of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) relating to Medicare payment for the interpretation of electrocardiograms (EKGs). Experience with the new Medicare fee schedule and comments from the beneficiary and physician communities regarding the inadequacy of payments for visit and consultation services supports the re-instate-

ment of separate physician payment for the interpretation of this important diagnostic test. Bundling these payments into visit and consultation services has resulted in larger payments to physicians rarely performing EKG interpretations and inadequate payments to those performing a large number of such tests.

Since resource-based relative value units were established for the interpretation of EKGs, the Committee believes that separate payments for this professional service should be recognized under the fee schedule. The provision in the Committee bill would implement this change on a budget-neutral basis through a modest reduction to other fee schedule amounts and payments for services not yet paid under the fee schedule.

HEARINGS

The Committee held no hearings on this legislation. However, the Committee did have the benefit of pertinent reports and investigations on matters related to the bill's provisions, including five reports prepared by the Subcommittee on Oversight of the Committee on Ways and Means, the Office of the Inspector General of DHHS, and the General Accounting Office.

COMMITTEE CONSIDERATION

On July 23, 1992, the Subcommittee on Health and the Environment met in open session to consider the bill H.R. 3837. The bill was amended by a Substitute Amendment to Title I and one additional amendment. The bill as amended was ordered reported, by voice vote, a quorum being present. On July 28, 1992, the Committee on Energy and Commerce met in open session and ordered reported the bill H.R. 3837 with amendments by voice vote, a quorum being present.

Pursuant to clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, no oversight findings or recommendations have been made by the Committee.

Committee on Government Operations

Pursuant to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Operations.

Committee Cost Estimate

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes that the Medicare portions of the bill, Title I of H.R. 3837, will result in reduced outlays of $1 million, $5 million, and $6 million in Fiscal Years 1993, 1994, and 1995, respectively.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 3, 1992.

Hon. JOHN DINGELL,
Chairman, Committee on Energy and Commerce, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for Title I of H.R. 3837, the Federal Program Improvement Act of 1992, as ordered reported by the House Committee on Energy and Commerce on July 28, 1992. An estimate for the amendment to restore separate payments for the interpretation of electrocardiograms is included.

H.R. 3837 would affect direct spending and receipts, and thus would be subject to pay-as-you-go procedures under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985. As a result, the estimate required under clause 8 of House Rule XXI also is attached.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

ROBERT D. REISCHAUER.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: Title I of H.R. 3837.
2. Bill title: Federal Program Improvement Act of 1992.
3. Bill status: As ordered reported by the House Committee on Energy and Commerce on July 28, 1992.
4. Bill purpose: Title I of H.R. 3837 would make a number of changes in the administration of the Medicare program.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1993	1994	1995	1996	1997
Direct spending:					
Title I—Medicare:					
Prohibition on carrier shopping:					
Estimated budget authority	−1	−5	−6	−7	−8
Estimated outlays	−1	−5	−6	−7	−8
EKG amendment:					
Estimated budget authority	−5	−10	−10	−15	−15
Estimated outlays	−5	−10	−10	−15	−15
Total—Estimated budget authority	−6	−15	−16	−22	−23
Total—Estimated outlays	−6	−15	−16	−22	−23

Basis of estimate: Title I—Medicare.

Carrier Shopping: H.R. 3837 includes several provisions relating to the reimbursement for durable medical equipment (DME) under the Medicare program. The only provision that has budgetary effects deals with the prohibition on carrier shopping. Under current practice, some DME suppliers are submitting claims for this equipment through the carrier with the highest reimbursement rates for the equipment. This provision would require suppliers to submit claims for DME, prosthetic devices, orthotics and prosthetics, and

ostomy bags and supplies related to ostomy care to the carrier whose geographic area includes the location where the items or services are actually provided to the patient. This change would take effect on July 1, 1993. Based on information from the Health Care Financing Administration (HCFA), this provision could save approximately two percent of DME reimbursements per year, or an estimated $27 million over the 1993–1997 period.

Secondary Payer Program: The bill would also include provisions relating to the Medicare Secondary Payer (MSP) program. This program identifies and collects reimbursements erroneously made when other health insurance exists (and is primary payer to Medicare). These provisions would strengthen the identification and enforcement mechanisms that HCFA can employ to collect these funds. Discussions with HCFA staff have indicated that any budget effects from these changes are likely to be small, but no data are available to develop a precise estimate.

Restore Separate Payments for EKGs: The bill also includes a provision that would reestablish separate payment for the interpretation of electrocardiograms (EKGs), when they are performed in conjunction with the physician's visit or consultation. The provision would result in the decrease of relative value units assigned to visits and consultations, and would lower the conversion factor used to calculate payments to physicians. The provision is designed to be budget-neutral with respect to physician payments. However, there will be some savings due to decreased payments for radiology services in hospital outpatient departments because those payments are calculated based on physician payment rates for those services.

6. Pay-as-you-go considerations: The Budget Enforcement Act of 1990 sets up pay-as-you-go procedures for legislation affecting direct spending or receipts through 1995. The benchmark against which changes in direct spending or receipts are measured is the baseline as described in the act.

The Medicare provisions of the bill would reduce direct spending. The estimate outlay effects are shown in the table below.

[By fiscal years, in millions of dollars]

	1992	1993	1994	1995
Title I—Medicare:				
Change in outlays	0	−6	−15	−16
Change in receipts	0	0	0	0

7. Estimated cost to State and local government: None.

8. Estimate comparison: None.

9. Previous CBO estimate: None.

10. Estimate prepared by: Lori Housman—Medicare; Scott Harrison—Medicare; Lisa Layman—Medicare.

11. Estimate approved by: Paul Van de Water (for C.G. Nuckols, Assistant Director for Budget Analysis).

CONGRESSIONAL BUDGET OFFICE ESTIMATE[1]

The applicable cost estimate of this act for all purposes of sections 252 and 253 of the Balanced Budget and Emergency Deficit Control Act of 1985 shall be as follows:

[By fiscal years, in millions of dollars]

	1992	1993	1994	1995
Change in outlays	0	−6	−15	−16
Change in receipts	(1)	(1)	(1)	(1)

[1] Not applicable.

Inflationary Impact Statement

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee makes the following statement with regard to the inflationary impact of the reported bill: the bill is clearly anti-inflationary since it would reduce Medicare outlays and lower health costs for beneficiaries.

Section-by-Section Analysis

Title I—Provisions Relating to the Medicare Program

SUBTITLE A. DURABLE MEDICAL EQUIPMENT

Section 101. Restrictions on certain marketing and sales activities

Suppliers would be prohibited from making unsolicited telephone contacts with Medicare beneficiaries regarding the furnishing of covered items of durable medical equipment, urological and ostomy bags and supplies, prosthetics and orthotics, unless the individual gives permission to the supplier, or the supplier has furnished the individual with a covered item within the proceding 15 months. Medicare would not pay for any items provided subsequent to a prohibited telephone contact by a supplier. Beneficiaries would not be liable for the cost of items provided as a result of prohibited telephone contacts, and the supplier would have to refund any money collect or be subject to civil monetary penalties.

Suppliers who knowingly make prohibited telephone contacts, to the extent that the contacts establish a pattern, would be excluded from programs under the Social Security Act. These provisions would be effective on enactment.

Section 102. Certification of suppliers of durable medical equipment

(a) Certification of durable medical equipment and other suppliers and application for supplier numbers

The Secretary would, be July 1, 1993, establish standards for the certification of suppliers of furable medical equipment, and for the application and issuance of supplier numbers for suppliers of such

[1] An estimate of Title I of H.R. 3837, the Federal Program Improvement Act of 1992, as ordered reported by the House Committee on Energy and Commerce on July 28, 1992. This estimate was transmitted by the Congressional Budget Office on August 3, 1992.

medical equipment. Entities that are already certified as providers under Medicare, including hospitals, home health agencies, hospices and skilled nursing facilities, would be excluded from the DME certification and supplier number requirements.

In order for a supplier to be certified by the Secretary, the supplier would have to (1) comply with all applicable State and Federal licensure and regulatory requirements, (2) maintain a physical facility and inventory on an appropriate site, (3) and have appropriate liability insurance.

Effective January 1, 1994, Medicare payments would not be made for covered items of durable medical equipment to suppliers who are not certified by the Secretary as meeting the applicable standards. Beneficiaries would not be liable for the cost of items provided by a supplier that is not certified by the Secretary, and such supplier would have to refund any money collected or be subject to a civil monetary penalty.

The Secretary would be prohibited from delegating the certification of suppliers to private certifying or accrediting agencies.

The Secretary would issue a single supplier number to each supplier under the Medicare program. Such number could include trailing digits that could be used to identify subsidiary or regional entities within a supplier.

The application for provider number for suppliers of durable medical equipment and other supplies, including prosthetic devices, and urological and ostomy care supplies, shall require the supplier to disclose information regarding its ownership and business practices. Specifically, the supplier shall provide: (1) information relating to ownership and managing employees as provided in current law; (2) the identity and billing number of other entities providing services for which payment may be made under the Medicare program with respect to which an owner or managing employee has, or has had, an ownership or control interest within the previous 3 years; (3) whether penalties have been assessed against such person under the Medicare or Medicaid programs, or whether such persons have been excluded from the Medicare or Medicaid programs; (4) the identity and existence of subcontracting or subsidiary business entities with which the provider is affiliated or doing business which are advertising or marketing firms directly or indirectly involved in sales of durable medical equipment or supplies to Medicare beneficiaries; (5) information on sales and billing practices, including whether the supplier engages in telemarketing and whether items are directly purchased, warehoused and shipped by the entity or supplied under arrangements with other suppliers; (6) documentation regarding certification as a durable medical equipment supplier by the Secretary; and (7) such other information as the Secretary may deem appropriate.

(b) Study of certification and quality standards

The Secretary would study whether additional certification and quality standards should be established for suppliers of durable medical equipment under the Medicare program. In conducting this study, the Secretary shall consult with organizations representing suppliers, and such other individuals or organizations the Secretary deems appropriate. The standards considered by the Sec-

retary in this study should include standards relating to: safety; patient records and rights; equipment management and maintenance; qualifications of employees including appropriate use of certified respiratory therapists; and internal quality assurance programs.

These provisions would be effective on enactment.

Section 103. Reform of procedures for filing, processing and reviewing claims

(a) Prohibition against carrier shopping

Suppliers would have to submit claims for durable medical equipment, prosthetic devices, orthotics and prosthetics, and ostomy bags and supplies related to ostomy care to the carrier whose geographic area includes the location at which the items or services are actually provided directly to the patient.

The Committee intends that the location at which the items and services are actually provided to the patient would, in general, be determined by location of the patient's place of residence. However, in cases where the patient is traveling and receives the items and services in a place other than his or her residence, payment would be based on the actual location that the items and services are provided. In addition, the Committee intends that this provision will be implemented simultaneously with the anticipated change to regional carriers which is scheduled for July 1, 1993.

(b) Certificates of medical necessity for items of durable medical equipment, orthotics, and prosthetics

The Secretary would be required to develop one or more standardized certificates of medical necessity for durable medical equipment, orthotic, and prosthetic devices, and services by July 1, 1993.

(c) Coverage and review criteria

The Secretary shall, by July 1, 1993, develop and establish uniform national coverage and utilization review criteria for 200 selected items of durable medical equipment, prosthetic devices, and orthotics and prosthetics, and surgical dressings. The Secretary shall consult with suppliers, beneficiaries, and appropriate medical specialties in developing the uniform standards. The 200 selected items shall be those items which the Secretary determines are frequently purchased or rented by beneficiaries, are frequently determined to be medically necessary, or are those for which the current coverage or utilization policies among carriers are inconsistent. The Secretary shall, on an annual basis, review coverage for items of durable medical equipment, prosthetic devices, or orthotics and prosthetics, and surgical dressing to determine whether additional national coverage or review criteria are appropriate, and develop such additional criteria on a timely basis.

The Secretary shall report to the Congress by January 1, 1994, on the impact of the uniform coverage and utilization criteria on claims processing, and the desirability of developing uniform policies for additional items.

The provisions under (a) would be effective for items and services provided on or after July 1, 1993; provisions under (b) and (c) would be effective on enactment.

Section 104. Adjustments for inherent reasonableness

(a) Adjustments made to final payment amounts

The authority for adjustments for inherent reasonableness would be clarified to indicate that the adjustment would apply to the durable medical equipment fee schedules, and to clarify that such adjustments would be based on the prices and costs applicable at the time the item is furnished.

(b) Adjustment required for certain items

The Secretary would be required to determine whether the payment amounts for decubitus care mattresses, and transcutaneous electrical nerve stimulators are inherently reasonable and to make such adjustments as the Secretary determines to be appropriate.

These provisions would be effective on enactment.

Section 105. Advanced determination requirements for potentially overused items

(a) Treatment for potentially overused items and advance determinations of coverage

Claims for items of DME that are potentially overused would be subject to special carrier scrutiny. The Secretary would publish, and periodically update, a list of such items. The list would include: seatlift mechanism; TENS equipment; power-driven scooters; decubitus care mattresses; and such other items of DME determined appropriate by the Secretary. The Secretary would include items that are either: (1) mass marketed directly to beneficiaries; (2) marketed with offers to waive the coinsurance, or marketed as "free" or "at no cost" to beneficiaries with Medigap coverage or other coverage; (3) subject to a consistent pattern of overutilization; or (4) frequently based on a lack of medical necessity.

For customized equipment and for equipment designated by the Secretary as potentially overused, suppliers could request prior approval of the item from a carrier in a form determined by the Secretary. The Secretary would establish standards for the timeliness of carrier responses to such requests, and would incorporate such standards into the evaluations of carriers' performance.

(b) Report on the implementation and review of advance determinations of potentially overused items

Not later than July 1, 1993, the Secretary shall submit a report to the Committee on Ways and Means, the Committee on Energy and Commerce of the House, and the Committee on Finance describing the steps taken to implement the advance determinations of potential overused items, together with an analysis of the effectiveness of such requirements in reducing unnecessary utilization of durable medical equipment.

These provisions would be effective on enactment.

Section 106. Physician ownership referral arrangements regarding durable medical equipment suppliers

Physicians would be prohibited from referring patients for durable medical equipment to entities with which they have a financial

relationship. This prohibition would be similar to that regarding clinical laboratory services. Exemptions to the prohibition would be similar to the current exemptions regarding clinical laboratory services.

The provisions would be effective for services provided on or after January 1, 1994.

Section 107. Reports and studies

(a) Items requiring improved definitions

The Secretary shall, in consultation with the Inspector General of the Department of Health and Human Services, manufacturers of durable medical equipment, and entities that establish quality standards for durable medical equipment, submit a report on changes made to improve definitions of items of durable medical equipment in the Health Care Financing Administration Common Procedure Codes, including improvements relating to the incorporation of updated quality considerations for the items. The Secretary shall submit the report to the Committee on Ways and Means, the Committee on Energy and Commerce of the House, and the Committee on Finance not later than January 1, 1993.

(b) Geographic variation among supplier costs compared to payment amounts

The Health Care Financing Administration (HCFA) would collect and analyze cost data to isolate the proration of suppliers' costs that are related to the "service" and "product" components of providing DME, prosthetic devices, ostomy bags and supplies, surgical dressings, and orthotics and prosthetics. In conducting this study, HCFA would consult with appropriate organizations.

HCFA would analyze the geographic variations in the cost of the service component. HCFA would develop an index that reflects geographic variations in suppliers' costs of providing the service component.

HCFA would submit a report of its findings to the Committee on Ways and Means, the Committee on Energy and Commerce of the House, and the Committee on Finance, including recommendations regarding the use of area adjustments for DME, prosthetic devices, ostomy bags and supplies, surgical dressings, and orthotics and prosthetics, and an analysis of the feasibility and desirability of establishing a national fee schedule for durable medical equipment. The Secretary should include recommendations relating to the design of a national fee schedule, including whether the fees should be based on the average or median of current payment amounts or other basis. The report, due on July 1, 1993, would include an impact analysis of the use of the index on suppliers.

(c) Criteria for treatment of items as prosthetic devices or orthotics and prosthetics

The Secretary shall submit a report to the Committee on Ways and Means, the Committee on Energy and Commerce of the House, and the Committee on Finance describing prosthetic devices, and orthotics and prosthetics that do not require individual fitting and adjustment, and shall include in such report an appropriate meth-

odology for determining payment for such items under Medicare. The report shall be submitted not later than July 1, 1993.

These provisions would be effective on enactment.

SUBTITLE B. SECONDARY PAYER IDENTIFICATION AND ENFORCEMENT

Section 111. Improving identification of Medicare secondary payer situation

(a) Survey of beneficiaries

The Administrator of the Health Care Financing Administration would be required to mail questionnaires to individuals, before the individual becomes entitled to benefits under Part A or enrolls in Part B, to determine whether the individual is covered under a primary plan.

The Secretary would enter into agreement with an entity to distribute questionnaires no later than January 1, 1993.

(b) Mandatory screening by providers and suppliers under part B

Providers and suppliers would be required to complete information on the Medicare claim form, to the best of their knowledge and on the basis of information provided from the beneficiary, concerning potential coverage under other health benefit plans.

Claims would be denied for items or services under Part B, if the portion of the claim form pertaining to other health benefit plans has not been completed.

Any entity that knowingly, willfully and repeatedly fails to complete the claim form, or provides inaccurate information would be subject to a civil money penalty of up to $2,000 for each incident.

The effective date for provisions under (a) is January 1, 1993; the provisions under (b) are effective for items and services furnished on or after January 1, 1993.

Section 112. Improvements in recovery of payments for primary payers

(a) Reporting requirements for fiscal intermediaries and carriers

Fiscal intermediaries and carriers would be required to submit reports to the Secretary no less than annually describing the steps taken to recover mistaken payments made for items or services for which payment has been made or could be made by a primary plan.

(b) Requirements for fiscal intermediary and carrier performance evaluation

The Secretary would be required to include, in its evaluation of fiscal intermediaries and carriers, their performance in recovering Medicare payments for which payment has been made or could be made by a primary plan.

(c) Deadline for reimbursement by primary payers

The Secretary would be permitted to charge interest, in addition to the amount of payment owed, if the payment is not received within 60 days after notice is given.

Provisions under (a) and (b) shall apply to contracts with fiscal intermediaries and carriers for years beginning with 1993. The 60-day deadline imposed under (c) would be effective for payments for items and services furnished on or after January 1, 1993.

Section 113. Study of effectiveness of secondary payer reforms

The Comptroller General would conduct a study to evaluate the effectiveness of the Medicare secondary payer requirements included in this subsection. This evaluation would include: the beneficiary survey; mandatory provider and supplier screening; new Medicare contractor performance criteria, and new reporting requirements for fiscal intermediaries and carriers. The study would also review the feasibility and desirability of using incentives and of permitting entities that are not engaged in the provision of group health insurance to serve as fiscal intermediaries and carriers, in order to improve collections from primary plans when Medicare is secondary payer.

The study would evaluate the extent to which such policies improve collections from primary plans when medicare is secondary payer and would make recommendations for further steps necessary to improve recovery of payments when Medicare is secondary payer.

The Comptroller General would submit interim findings to the Committee on Ways and Means and Committee on Energy and Commerce of the House and the Committee on Finance of the Senate.

The provisions under this section would be effective on enactment.

SUBTITLE C. PAYMENT FOR INTERPRETATION OF ELECTROCARDIOGRAMS

Section 121. Permitting separate payment for interpretation of electrocardiograms

This provision would restore separate Medicare payments for the interpretation of electrocardiograms (EKGs) under the Medicare Fee Schedule. Under provisions included in the Omnibus Budget Reconciliation Act of 1990 (P.L. 101–508), separate payments for this physician service were eliminated. It was assumed that compensation for EKG interpretations would be included in the new visit and consultation codes established by the Medicare Fee Schedule.

This section would restore separate payments for EKG interpretations on a budget-neutral basis. As a result, there would be no increase or decrease in aggregate Medicare payments for physicians' services. Payments under the new fee schedule and payments for services not yet paid on the basis of the fee schedule would be reduced by a uniform amount to achieve budget neutrality.

The Committee recognizes that experience with the new fee schedule indicates that bundling payments for the interpretation of

EKGs in visit and consultation codes is not appropriate. Current law has resulted in increased visit and consultation fees to physicians who rarely, if ever, order EKGs, and inadequate payments to physicians performing a large number of such services. Restoration of separate payments for this important diagnostic service would result in more accurate payments and would assure patient access.

The provision would be effective for services provided on or after January 1, 1993.

Agency Views

No agency views were submitted to the Committee on H.R. 3837.

Changes in Existing Law Made by the Bill, as Reported

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Social Security Act

* * * * * * *

TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

* * * * * * *

EVIDENCE, PROCEDURE, AND CERTIFICATION FOR PAYMENT

SEC. 205. (a) * * *

* * * * * * *

USE OF DEATH CERTIFICATES TO CORRECT PROGRAM INFORMATION

(r)(1) The Secretary shall undertake to establish a program under which—

(A) * * *

(B) there will be (i) a comparison of such information on such individuals with information on such individuals in the records being used in the administration of this Act, (ii) validation of the results of such comparisons, and (iii) corrections in such records to accurately reflect the status of such individuals.

Any contract entered into pursuant to subparagraph (A) shall not include any restriction on the use of information obtained by the Secretary pursuant to such contract, except to the extent that such use may be restricted under paragraph (6).

(2)*(A)* Each State (or political subdivision thereof) which furnishes the Secretary with information on records of deaths in the State or subdivision under this subsection may be paid by the Secretary from amounts available for administration of this Act the reasonable costs (established by the Secretary in consultations with States) for transcribing and transmitting such information to the Secretary.

(B) Notwithstanding section 7(a)(2)(B) of the Privacy Act of 1974 and clauses (i) and (v) of subsection (c)(2)(C) of this section, any State which is not a party to a contract with the Secretary meeting the requirements of paragraph (1) (and any political subdivision thereof) may not utilize an individual's social security account number in the administration of any driver's license or motor vehicle registration law.

(3) In the case of individuals with respect to whom federally funded benefits are provided by (or through) a Federal [or State] agency other than under this Act, the Secretary shall to the extent feasible provide such information through a cooperative arrangement with such agency, for ensuring proper payment of those benefits with respect to such individuals if—

(A) under such arrangement the agency provides reimbursement to the Secretary for the reasonable cost of carrying out such arrangement, and

(B) such arrangement does not conflict with the duties of the Secretary under paragraph (1).

[(4) The Secretary may enter into similar agreements with States to provide information for their use in programs wholly funded by the States if the requirements of subparagraphs (A) and (B) of paragraph (3) are met.]

(4)(A) In the case of individuals with respect to whom federally funded benefits are provided by (or through) a State agency other than under this Act, the Secretary shall to the extent feasible provide such information free of charge through a cooperative arrangement with such agency, for ensuring proper payment of those benefits with respect to such individuals, if such arrangement does not conflict with the duties of the Secretary under paragraph (1).

(B) The Secretary may enter into similar agreements with States to provide information free of charge for their use in programs wholly funded by the States if such arrangement does not conflict with the duties of the Secretary under paragraph (1).

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

Part A—Hospital Insurance Benefits for the Aged and Disabled

* * * * * * *

Sec. 1816. (a) * * *

* * * * * * *

(f)(1) In order to determine whether the Secretary should enter into, renew, or terminate an agreement under this section with an agency or organization, whether the Secretary should assign or reassign a provider of services to an agency or organization, and whether the Secretary should designate an agency or organization to perform services with respect to a class of providers of services, the Secretary shall develop standards, criteria, and procedures to evaluate such agency's or organization's (A) overall performance of

claims [processing] *processing (including the agency's or organization's success in recovering payments made under this title for services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A))* and other related functions required to be performed by such an agency or organization under an agreement entered into under this section, and (B) performance of such functions with respect to specific providers of services, and the Secretary shall establish standards and criteria with respect to the efficient and effective administration of this part. No agency or organization shall be found under such standards and criteria not be efficient or effective or to be less efficient or effective solely on the ground that the agency or organization serves only providers located in a single State.

* * * * * * *

(k) An agreement with an agency or organization under this section shall require that such agency or organization submit an annual report to the Secretary describing the steps taken to recover payments made for items or services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)).

* * * * * * *

Part B—Supplementary Medical Insurance Benefits for the Aged and Disabled

* * * * * * *

special payment rules for particular items and services

Sec. 1834. (a) Payment for Durable Medical Equipment.—

(1) * * *

* * * * * * *

(10) Exceptions and adjustments.—

(A) * * *

(B) Adjustment for inherent reasonableness.—For covered items furnished on or after January 1, 1991, the Secretary is authorized to apply the provisions of paragraphs (8) and (9) (other than subparagraph (D)) of section 1842(b) to covered items and suppliers of such items and payments under this subsection as such provisions apply to physicians' services and physicians and a reasonable charge under section 1842(b). *In applying such provisions to payments for an item under this subsection, the Secretary shall make adjustments to the payment basis for the item described in paragraph (1)(B) if the Secretary determines (in accordance with such provisions and on the basis of prices and costs applicable at the time the item is furnished) that such payment basis is not inherently reasonable.*

* * * * * * *

(11) Improper billing and requirement of physician order.—

(A) * * *

* * * * * * *

(C) CARRIER DETERMINATIONS FOR CERTAIN ITEMS IN ADVANCE.—Upon the request of a supplier, a carrier shall determine in advance whether payment for an item may not be made under this subsection because of the application of section 1862(a)(1) if—

(i) the item is a customized item (other than inexpensive items specified by the Secretary); or

(ii) the item is subject to special carrier scrutiny under paragraph (20)(B).

[(12) REGIONAL CARRIERS.—The Secretary may designate, by regulation under section 1842, one carrier for one or more entire regions to process all claims within the region for covered items under this section.]

(12) USE OF CARRIERS TO PROCESS CLAIMS.—

(A) DESIGNATION OF REGIONAL CARRIERS.—The Secretary may designate, by regulation under section 1842, one carrier for one or more entire regions to process all claims within the region for covered items under this section.

(B) PROHIBITION AGAINST CARRIER SHOPPING.—(i) No supplier of a covered item may present or cause to be presented a claim for payment under this part unless such claim is presented to the appropriate carrier.

(ii) For purposes of clause (i), the term "appropriate carrier" means the carrier having jurisdiction over the geographic area that includes the location where the item was directly furnished to the patient.

* * * * * * *

(17) PROHIBITION AGAINST UNSOLICITED TELEPHONE CONTACTS BY SUPPLIERS.—

(A) IN GENERAL.—A supplier of a covered item under this subsection may not contact an individual enrolled under this part by telephone regarding the furnishing of a covered item to the individual (other than a covered item the supplier has already furnished to the individual) unless—

(i) the individual gives permission to the supplier to make contact by telephone for such purpose; or

(ii) the supplier has furnished a covered item under this subsection to the individual during the 15-month period preceding the date on which the supplier contacts the individual for such purpose.

(B) PROHIBITING PAYMENT FOR ITEMS FURNISHED SUBSEQUENT TO UNSOLICITED CONTACTS.—If a supplier knowingly contacts an individual in violation of subparagraph (A), no payment may be made under this part for any item subsequently furnished to the individual by the supplier.

(C) EXCLUSION FROM PROGRAM FOR SUPPLIERS ENGAGING IN PATTERN OF UNSOLICITED CONTACTS.—If a supplier knowingly contacts individuals in violation of subparagraph (A) to such an extent that the supplier's conduct establishes a pattern of contacts in violation of such subparagraph, the

Secretary shall exclude the supplier for participation in the programs under this Act, in accordance with the procedures set forth in subsections (c), (f), and (g) of section 1128.

(18) REFUND OF AMOUNTS COLLECTED FOR CERTAIN DISALLOWED ITEMS.—

(A) IN GENERAL.—If a nonparticipating supplier furnishes to an individual enrolled under this part a covered item for which no payment may be made under this part by reason of paragraph (17)(B) or paragraph (19)(A), the supplier shall refund on a timely basis to the patient (and shall be liable to the patient for) any amounts collected from the patient for the item, unless—

(i) the supplier establishes that the supplier did not know and could not reasonably have been expected to know that payment may not be made for the item by reason of paragraph (17)(B) or paragraph (19)(A), or

(ii) before the item was furnished, the patient was informed that payment under this part may not be made for that item and the patient has agreed to pay for that item.

(B) SANCTIONS.—If a supplier knowingly and willfully fails to make refunds in violation of subparagraph (A), the Secretary may apply sanctions against the supplier in accordance with section 1842(j)(2).

(C) NOTICE.—Each carrier with a contract in effect under this part with respect to suppliers of covered items shall send any notice of denial of payment for covered items by reason of paragraph (17)(B) or paragraph (19)(A) and for which payment is not requested on an assignment-related basis to the supplier and the patient involved.

(D) TIMELY BASIS DEFINED—A refund under subparagraph (A) is considered to be on a timely basis only if—

(i) in the case of a supplier who does not request reconsideration or seek appeal on a timely basis, the refund is made within 30 days after the date the supplier receives a denial notice under subparagraph (C), or

(ii) in the case in which such a reconsideration or appeal is taken, the refund is made within 15 days after the date the supplier receives notice of an adverse determination on reconsideration or appeal.

(19) CERTIFICATION OF SUPPLIERS.—

(A) IN GENERAL.—Notwithstanding any other provision of this Act (except as provided in subparagraph (D)), no payment may be made under this part for covered items furnished on or after January 1, 1994, unless the supplier furnishing the item meets the standards for certification described in subparagraph (B).

(B) STANDARDS FOR CERTIFICATION.—A supplier meets the standards for certification described in this subparagraph if (in accordance with regulations of the Secretary) the supplier—

(i) is in compliance with all applicable State and Federal licensure and regulatory requirements;

(ii) maintains a physical facility and inventory on an appropriate site;

(iii) has appropriate liability insurance;

(iv) meets such other appropriate standards as the Secretary may establish by regulation.

(C) PROHIBITION AGAINST DELEGATION OF CERTIFICATIONS.—The Secretary may not delegate the responsibility to certify suppliers under subparagraph (A) to any non-governmental entity.

(D) EXCEPTION FOR SUPPLIERS WITH EXISTING PROVIDER AGREEMENTS.—Subparagraph (A) shall not apply with respect to covered items furnished by a supplier that is a provider of services that has in effect an agreement with the Secretary under section 1866(a).

(20) SPECIAL TREATMENT FOR POTENTIALLY OVERUSED ITEMS.—

(A) DEVELOPMENT OF LIST OF ITEMS BY SECRETARY.—The Secretary shall develop and periodically update a list of items for which payment may be made under this subsection that are potentially overused, and shall include in such list seat-lift mechanisms, transcutaneous electrical nerve stimulators, motorized scooters, decubitus care mattresses, and any such other item determined by the Secretary to be potentially overused on the basis of any of the following criteria—

(i) the item is marketed directly to potential patients;

(ii) the item is marketed with an offer to potential patients to waive the costs of coinsurance associated with the item or is marketed as being available at no cost to policyholders of a medicare supplemental policy (as defined in section 1882(g)(1);

(iii) the item has been subject to a consistent pattern of overutilization; or

(iv) a high proportion of claims for payment for such item under this part may not be made because of the application of section 1862(a)(1)

(B) ITEMS SUBJECT TO SPECIAL CARRIER SCRUTINY.—Payment may not be made under this part of any item contained in the list developed by the Secretary under subparagraph (A) unless the carrier has subjected the claim for payment for the item to special scrutiny or has followed the procedures described in paragraph (11)(C) with respect to the item.

* * * * * * *

(h) PAYMENT FOR PROSTHETIC DEVICES AND ORTHOTICS AND PROSTHETICS.—

(1) * * *

* * * * * * *

(3) APPLICABILITY OF CERTAIN PROVISIONS RELATING TO DURABLE MEDICAL EQUIPMENT.—[Paragraph (12)] *Paragraphs (12) and (17)* and subparagraphs (A) and (B) of [paragraph (10) and paragraph (11)] *paragraphs (10) and (11)* of subsection (a) shall apply to pros-

thetic devices, orthotics, and prosthetics in the same manner as such provisions apply to covered items under such subsection.

* * * * * * *

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *
(b)(1) * * *
(2)(A) * * *

* * * * * * *

(D) In addition to any other standards and criteria established by the Secretary for evaluating carrier performance under this paragraph relating to avoiding erroneous payments, the Secretary shall establish standards and criteria relating to the carrier's success in recovering payments made under this part for items or services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)).

3) Each such contract shall provide that the carrier—

(A) * * *

* * * * * * *

(G) will provide to each nonparticipating physician, at the beginning of each year, a list of the physician's limiting charges established under section 1848(g)(2) for the year for the physician's services mostly commonly furnished by that physician; [and]

(H) if it makes determinations or payments with respect to physicians' services, will implement—

(i) programs to recruit and retain physicians as participating physicians in the area served by the carrier, including educational and outreach activities and the use of professional relations personnel to handle billing and other problems relating to payment of claims of participating physicians; and

(ii) programs to familiarize beneficiaries with the participating physician program and to assist such beneficiaries in locating participating physicians; and

(I) will submit annual reports to the Secretary describing the steps taken to recover payments made under this part for items or services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)).

* * * * * * *

(c)(1) * * *

* * * * * * *

(4) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall require the carrier to meet criteria developed by the Secretary to measure the timeliness of carrier responses to requests for payment of items described in section 1834(a)(11)(C).

* * * * * * *

PAYMENT FOR PHYSICIANS' SERVICES

SEC. 1848. (a)

(b) ESTABLISHMENT OF FEE SCHEDULES.—

(1) * * *

[(3) TREATMENT OF INTERPRETATION OF ELECTROCARDIOGRAMS.—If payment is made under this part for a visit to a physician or consultation with a physician and, as part of or in conjunction with the visit or consultation there is an electrocardiogram performed or ordered to be performed, no payment may be made under this part with respect to the interpretation of the electrocardiogram and no physician may bill an individual enrolled under this part separately for such an interpretation. If a physician knowingly and willfully bills one or more individuals in violation of the previous sentence, the Secretary may apply sanctions against the physician or entity in accordance with section 1842(j)(2).]

PART C—MISCELLANEOUS PROVISIONS

* * * * * * *

EXCLUSIONS FROM COVERAGE AND MEDICARE AS SECONDARY PAYER

SEC. 1862. (a) * * *

(b) MEDICARE AS SECONDARY PAYER.—

(1) * * *

(2) MEDICARE SECONDARY PAYER.—

(A) * * *

(B) CONDITIONAL PAYMENT.—

(i) [PRIMARY PLANS] *REPAYMENT REQUIRED.*—Any payment under this title with respect to any item or service to which subparagraph (A) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been or could be made under such subparagraph. *If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date such notice or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).*

(5) IDENTIFICATION OF SECONDARY PAYER SITUATIONS.—

(A) * * *

* * * * * * *

(D) OBTAINING INFORMATION FROM BENEFICIARIES.—Before an individual applies for benefits under part A or enrolls under part B, the Administrator shall mail the individual a questionnaire to obtain information on whether the individual is covered under a primary plan and the nature of the coverage pro-

vided under the plan, including the name, address, and identifying number of the plan.

(6) SCREENING REQUIREMENTS FOR PROVIDERS AND SUPPLIERS.—

(a) IN GENERAL.—Notwithstanding any other provision of this title, no payment may be made for any item or service furnished under part B unless the entity furnishing such item or service completes (to the best of its knowledge and on the basis of information obtained from the individual to whom the item or service is furnished) the portion of the claim form relating to the availability of other health benefit plans.

(B) PENALTIES.—An entity that knowingly, willfully, and repeatedly fails to complete a claim form in accordance with subparagraph (A) or provides inaccurate information relating to the availability of other health benefit plans on a claim form under such subparagraph shall be subject to a civil money penalty of not to exceed $2,000 for each such incident. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

* * * * * * *

LIMITATION ON CERTAIN PHYSICIAN REFERRALS

SEC. 1877. (a) PROHIBTION OF CERTAIN REFERRALS.—

(1) IN GENERAL.—Except as provided in subsection, (b), if a physician (or immediate family member of such physician) has a financial relationship with an entity specified in paragraph (2), then—

(A) the physician may not make a referral to the entity for the furnishing of clinical laboratory services *or durable medical equipment* for which payment otherwise may be made under this title, and

(B) the entity may not present or cause to be presented a claim under this title or bill to any individual, third party payor, or other entity for clinical laboratory services *or durable medical equipment* furnished pursuant to a referral prohibited under subparagraph (A).

(2) FINANCIAL RELATIONSHIP SPECIFIED.—For purposes of this section, a financial relationship of a physician (or immediate family member) with an entity specified in this paragraph is—

(A) except as provided in subsections (c) and (d), an ownership or investment interest in the entity; or

(B) except as provided in subsection (e), a compensation arrangement (as defined in subsection (h)(1)(A)) between the physician (or immediate family member) and the entity.

An ownership or investment interest described in subparagraph (A) may be through equity, debt, or other means.

(b) GENERAL EXCEPTIONS TO BOTH OWNERSHIP AND COMPENSATION ARRANGEMENT PROHIBITIONS.—Subsection (a)(1) shall not apply in the following cases:

(1) * * *

(2) IN-OFFICE ANCILLARY SERVICES.—In the case of services—

(A) that are furnished—

(i) * * *

(ii)(I) in a building in which the referring physician (or another physician who is a member of the same group practice) furnishes physicians' services unrelated to the furnishing of clinical laboratory services *or durable medical equipment*, or

(II) in the case of a referring physician who is a member of a group practice, in another building which is used by the group practice for the centralized provision of the group's clinical [laboratory services,] *laboratory services of furnishing of the group's durable medical equipment,* and

(d) ADDITIONAL EXCEPTIONS RELATED ONLY TO OWNERSHIP OR INVESTMENT PROHIBITION.—The following, if not otherwise excepted under subsection (b), shall not be considered to be an ownership or investment interest described in subsection (a)(2)(A):

(1) HOSPITALS IN PUERTO RICO.—In the case of clinical laboratory services *or durable medical equipment* provided by a hospital located in Puerto Rico.

(2) RURAL PROVIDER.—In the case of clinical laboratory services *or durable medical equipment* if the laboratory furnishing the services *or the supplier furnishing the equipment* is in a rural area (as defined in section 1886(d)(2)(D)).

(3) HOSPITAL OWNERSHIP.—In the case of clinical laboratory services *or durable medical equipment* provided *or furnished* by a hospital (other than a hospital described in paragraph (1)) if—

(A) the referring physician is authorized to perform services *or furnish equipment* at the hospital, and

(B) the ownership or investment interest is in the hospital itself (and not merely in a subdivision thereof).

* * * * * * *

(g) SANCTIONS.—

(1) DENIAL OF PAYMENT.—No payment may be made under this title for a clinical laboratory service *or an item of durable medical equipment* which is provided in violation of subsection (a)(1).

* * * * * * *

(3) CIVIL MONEY PENALTY AND EXCLUSION FOR IMPROPER CLAIMS.—Any person that presents or causes to be presented a bill or a claim for a service *or item* that such person knows or should know is for a service *or item* for which payment may not be made under paragraph (1) or for which a refund has not been made under paragraph (2) shall be subject to a civil money penalty of not more than $15,000 for each such service *or item*. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

* * * * * * *

(h) DEFINITIONS.—For purposes of this section:
(1) * * *

* * * * * * *

(B) OTHER ITEMS.—Except as provided in subparagraph (C), the request or establishment of a plan of care by a physician which includes the provision of the clinical laboratory service *or the furnishing of the item of durable medical equipment* constitutes a "referral" by a "referring physician".

* * * * * * *

SECTION 5 OF THE ACT OF FEBRUARY 13, 1911

CHAP. 46.—An Act to provide for the lading or unlading of vessels at night, the preliminary entry of vessels, and for other purposes

[SEC. 5. That the Secretary of the Treasury shall fix a reasonable rate of extra compensation for overtime services of customs officers and employees who may be required to remain on duty between the hours of five o'clock postmeridian and eight o'clock antemeridian, or on Sundays or holidays, to perform services in connection with the lading or unlading of cargo, or the lading of cargo or merchandise for transportation in bond or for exportation in bond or for exportation with benefit of drawback, or in connection with the receiving or delivery of cargo on or from the wharf, or in connection with the unlading, receiving, or examination of passengers' baggage, such rates to be fixed on the basis of one-half day's additional pay for each two hours or fraction thereof of at least one hour that the overtime extends beyond five o'clock postmeridian (but not to exceed two and one-half days' pay for the full period from five o'clock postmeridian to eight o'clock antemeridian), and two additional days' pay for Sunday or holiday duty. The said extra compensation shall be paid by the master, owner, agency, or consignee of such vessel or other conveyance whenever such special license or permit for immediate lading or unlading or for lading or unlading at night or on Sundays or holidays shall be granted to the appropriate customs officer, who shall pay the same to the several customs officers and employees entitled thereto according the the rates fixed therefor by the Secretary of the Treasury: *Provided,* That such extra compensation shall be paid if such officers or employees have been ordered to report for duty and have so reported, whether the actual lading, unlading, receiving, delivery, or examination takes place or not. Customs officers acting as boarding officers are hereby authorized to administer the oath or affirmation herein provided for, and such boarding officers shall be allowed extra compensation for services in boarding vessels at night or on Sundays or holidays at the rates prescribed by the Secretary of the Treasury as herein provided, the said extra compensation to be paid by the master, owner, agent, or consignee of such vessel: *Provided further,* That in those ports where customary working hours are other than those hereinabove mentioned, the appropriate customs officer is vested with authority to regulate the hours of customs employees so as to agree with prevailing working hours in

said ports, but nothing contained in this proviso shall be construed in any manner to affect or alter the length of a working day for customs employees or the overtime pay herein fixed.]

SEC. 5 OVERTIME AND PREMIUM PAY FOR CUSTOMS OFFICERS.

(a) OVERTIME PAY.—

(1) IN GENERAL.—Subject to paragraph (2) and subsection (c), a customs officer who is officially assigned to perform work in excess of 40 hours in the administrative workweek of the officer or in excess of 8 hours in a day shall be compensated for that work at an hourly rate of pay that is equal to 2 times the hourly rate of the basic pay of the officer. For purposes of this paragraph, the hourly rate of basic pay for a customs officer does not include any premium pay provided for under subsection(b).

(2) SPECIAL PROVISIONS RELATING TO OVERTIME WORK ON CALL BACK BASIS.—

(A) MINIMUM DURATION.—Any work for which compensation is authorized under paragraph (1) and for which the customs officer is required to return to the officer's place of work shall be treated as being not less than 2 hours in duration; but only if such work begins at least 1 hour after the end of any previous regularly scheduled work assignment.

(B) COMPENSATION FOR COMMUTING TIME.—

(i) IN GENERAL. Except as provided in clause (ii), in addition to the compensation authorized under paragraph (1) for work to which subparagraph (A) applies, the customs officer is entitled to be paid, as compensation for commuting time, an amount equal to 3 times the hourly rate of basic pay of the officer.

(ii) EXCEPTION.—Compensation for commuting time is not payable under clause (i) if the work for which compensation is authorized under paragraph (1) commences within 2 hours of the next regularly scheduled work assignment of the customs officer.

(b) PREMIUM PAY FOR CUSTOMS OFFICERS.—

(1) NIGHT WORK DIFFERENTIAL.—

(A) 3 P.M. TO MIDNIGHT SHIFTWORK.—If the majority of the hours of regularly scheduled work of a customs officer occur during the period beginning at 3 p.m. and ending at 12 a.m., the officer is entitled to pay for work during such period (except for work to which paragraph (2) or (3) applies) at the officer's hourly rate of basic pay plus premium pay amounting to 15 percent of that basic rate.

(B) 11 P.M. TO 8 A.M. SHIFTWORK.—If the majority of the hours of regularly scheduled work of a customs officer occur during the period beginning at 11 p.m. and ending at 8 a.m., the officer is entitled to pay for work during such period (except for work to which paragraph (2) or (3) applies) at the officer's hourly rate of basic pay plus premium pay amounting to 20 percent of that basic rate.

(2) SUNDAY DIFFERENTIAL.—A customs officer who performs any regularly scheduled work on a Sunday that is not a holiday

is entitled to pay for that work at the officer's hourly rate of basic pay plus premium pay amounting to 50 percent of that basic rate.

(3) HOLIDAY DIFFERENTIAL.—A customs officer who performs any regularly scheduled work on a holiday is entitled to pay for that work at the officer's hourly rate of basic pay plus premium pay amounting to 100 percent of that basic rate.

(4) TREATMENT OF PREMIUM PAY.—Premium pay provided for under this subsection may not be treated as being overtime pay or compensation for any purpose.

(c) LIMITATIONS.—

(1) FISCAL YEAR CAP.—The aggregate of overtime pay under subsection (a) (including commuting compensation under subsection (a)(2)(B) and premium pay under subsection (b) that a customs officer may be paid in any fiscal year may not exceed $25,000; except that the Commissioner of Customs or his designee may waive this limitation in individual cases in order to prevent excessive costs or to meet emergency requirements of the Customs Service.

(2) EXCLUSIVITY OF PAY UNDER THIS SECTION.—A customs officer who receives overtime pay under subsection (a) or premium pay under subsection (b) for time worked may not receive pay or other compensation for that work under any other provision of law.

(d) REGULATIONS.—The Secretary of the Treasury shall prescribe such regulations as are necessary or appropriate to carry out this section, including regulations—

(1) to ensure that callback work assignments are commensurate with the overtime pay authorized for such work; and

(2) to prevent the disproportionate assignment of overtime work to customs officers who are near to retirement.

(e) DEFINITIONS.—As used in this section:

(1) The term "customs officer" means an individual performing those functions specified by regulation by the Secretary of the Treasury for a customs inspector or canine enforcement officer. Such functions shall be consistent with such applicable standards as may be promulgated by the Office of Personnel Management.

(2) The term "holiday" means any day designated as a holiday under a Federal statute or Executive order.

SECTION 2 OF THE ACT OF JUNE 3, 1944

AN ACT To amend section 451 of the Tariff Act of 1930, and for other purposes.

[SEC. 2. Notwithstanding any provision of law to the contrary, the extra compensation of customs officers and employees heretofore assigned to the performance of inspection services in connection with traffic over highways or toll bridges, through toll tunnels, or on ferries within the definition of the term "ferry" in section 1 of this Act on Sundays or holidays prior to the date of the enactment of this Act, which is payable on the basis prescribed by the said section 5 of the Act of February 13, 1911, as amended, shall be payable by the United States without reimbursement by the appli-

cants for such services or any other person. Any reimbursement of compensation made payable without reimbursement by this section which has accrued and been collected since January 6, 1941, shall be refunded. The necessary moneys to carry out the provisions of this Act are hereby authorized to be appropriated from the general fund of the Treasury.]

SECTION 450 OF THE TARIFF ACT OF 1930

SEC. 450. UNLADING ON SUNDAYS, HOLIDAYS, OR [AT NIGHT] *DURING OVERTIME HOURS.*

No merchandise, baggage, or passengers arriving in the United States from any foreign port or place, and no bonded merchandise or baggage being transported from one port to another, shall be unladen from the carrying aircraft, vessel or vehicle on Sunday, a holiday, or [at night] *during overtime hours*, except under special license granted by the appropriate customs officer under such regulations as the Secretary of the Treasury may prescribe.

SECTION 13031 OF THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

SEC. 13031. FEES FOR CERTAIN CUSTOMS SERVICES.

(a) * * *

* * * * * * *

(f) Disposition of fees.—(1) * * *

* * * * * * *

(3)(A) The Secretary of the Treasury, in accordance with section 524 of the Tariff Act of 1930 and subject to subparagraph (B), shall directly reimburse, from the fees collected under subsection (a) (other than subsection (a) (9) or (10)), each appropriation for the amount paid out of that appropriation for the costs incurred by the Secretary—

[(i) in providing—

[I] inspectional overtime services, and

[(II) all preclearance services for which the recipients of such services are not required to reimburse the Secretary of the Treasury, and]

(i) in—

(I) paying overtime compensation and premium pay under section 5 (a) and (b) of the Act of February 13, 1911,

(II) paying agency contributions to the Civil Service Retirement and Disability Fund to match deductions from the overtime compensation paid under subclause (I), and

(III) providing all preclearance services for which the recipients of such services are not required to reimburse the Secretary of the Treasury, and

* * * * * * *

(B) Reimbursement of appropriations under this paragraph—

(i) [except for costs described in subparagraph (A)(i) (I) and (II),] shall be subject to apportionment or similar administrative practices;

* * * * * * *

[(D) At the close of each fiscal year, the Secretary of the Treasury shall submit a report to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives summarizing the expenditures, on a port-by-port basis, for which reimbursement has been provided under subparagraph (A)(ii).]

(D) At the close of each fiscal year, the Secretary of the Treasury shall submit a report to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives—

(i) containing a detailed accounting of all expenditures from the Customs User Fee Account during such year, including a summary of the expenditures, on a port-by-port basis, for which reimbursement has been provided under subparagraph (A)(ii); and

(ii) containing a listing of all callback assignments of customs officers for which overtime compensation was paid under section 5(a) of the Act of February 13, 1911, and that were less than 1 hour in duration.

* * * * * * *

SECTION 8331 OF TITLE 5, UNITED STATES CODE

§ 8331. Definitions

For the purpose of this subchapter—

(1) * * *

* * * * * * *

(3) "basic pay" includes—

(A) * * *

* * * * * * *

(C) premium pay under section 5545(c)(1) of this title; [and]

(D) with respect to a law enforcement officer, premium pay under section 5545(c)(2) of this title [;]; *and*

(E) with respect to a customs officer (referred to in subsection (e)(1) of section 5 of the Act of February 13, 1911), compensation for overtime inspectional services provided for under subsection (a) of such section 5, but not to exceed 50 percent of any statutory maximum in overtime pay for customs officers which is in effect for the year involved;

but does not include bonuses, allowances, overtime pay, military pay, pay given in addition to the base pay of the position as fixed by law or regulation except as provided by [subparagraphs (B), (C), and (D) of this paragraph,] *subparagraphs (B), (C), (D), and (E) of this paragraph* retroactive pay under section 5344 of this title in the case of a retired or deceased employee,

uniform allowances under section 5901 of this title, or lump-sum leave payments under subchapter VI of chapter 55 of this title. For an employee paid on a fee basis, the maximum amount of basic pay which may be used is $10,000;

* * * * * * *